Complete Summary

GUIDELINE TITLE

Domestic violence.

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Nov. 51 p. [111 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Nov. 40 p.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Domestic violence

GUIDELINE CATEGORY

Counseling
Risk Assessment
Screening

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

- To increase training opportunities for staff for screening and assessment of domestic violence
- To improve the knowledge of health care professionals of community resources (shelters, domestic violence advocacy services) for domestic violence
- To facilitate the establishment of the health care setting as a safe, comfortable and appropriate place in which to discuss issues of domestic violence
- To improve the identification of victims of domestic violence and offer resources

TARGET POPULATION

All victims or potential victims from all ethnic groups, of partner abuse and violence, including adolescents through seniors, and heterosexuals and same-sex relationships

Child abuse and vulnerable adult abuse are outside the boundaries of this guideline.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Screening measures for domestic violence
2. Standard care of injuries and/or symptoms of domestic violence
3. Staff and patient education on domestic violence
4. Documentation procedures for health care providers dealing with domestic violence
5. Referral and use of resource information

MAJOR OUTCOMES CONSIDERED

- Rate of mental disorders, depression in physically abused women
- Rate of physical abuse during pregnancy
- Effectiveness of various screening methods for domestic abuse

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Institute Partners: System-Wide Review

The guideline annotation, discussion and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member groups during an eight-week review period.

Each of the Institute's participating member groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating member groups following implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

Guideline Work Group

Following the completion of the review period, the guideline work group meets 1 to 2 times to review the input received. The original guideline is revised as necessary and a written response is prepared to address each of the responses received from member groups. Two members of the Committee on Evidence-Based Practice carefully review the input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of four questions: (1) Is there consensus among all ICSI member groups and hospitals on the content of the guideline document? (2) Has the drafting work group answered all criticisms reasonably from the member groups? (3) Within the knowledge of the appointed reviewer, is the evidence cited in the document current and not out-of-date? (4) Is the document sufficiently similar to the prior edition that a more thorough review (critical review) is not needed by the member group? The committee then either approves the guideline for release as submitted or negotiates changes with the work group representative present at the meeting.

Pilot Test

Member groups may introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer and other practice systems. Evaluation and assessment occurs throughout the pilot test phase, which usually lasts for three-six months. At the end of the pilot test phase, ICSI staff and the leader of the work group conduct an interview with the member groups participating in the pilot test phase to review their experience and gather comments, suggestions, and implementation tools.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline, the Committee on Evidence-Based Practice reviews the revised guideline and approves it for release.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The recommendations for the management of domestic violence are presented in the form of an algorithm with 12 components, accompanied by detailed annotations. An algorithm is provided for Domestic Violence; clinical highlights and selected annotations (numbered to correspond with the algorithm) follow.

Class of evidence (A-D, M, R, X) definitions are provided at the end of the "Major Recommendations" field.

Clinical Highlights

1. Domestic violence screening and assessment should be a consideration in all patient encounters and should be conducted in private, with only the provider and the patient present. In certain situations a trusted interpreter or language line service (not a friend or a family member) may be necessary. Simply raising the question and affirming the difficulty of an abusive situation is, in and of itself, an important intervention. You cannot and do not have to fix the problem. (Annotations #1, 2, 7, 10)
2. Raise clinic and patient awareness regarding signs and symptoms of domestic violence. Possible strategies include:
    - Staff training (both clinical and office)
    - Signage in the clinic, emergency room or Urgent Care
    - Brochures/literature in the reception area and examining rooms

    (Annotation #1)

3. Staff should have a heightened awareness of a possible domestic violence situation when the patient presents with:
    - Somatic complaints without diagnosis (chronic pain, fatigue, headache)
    - Post-traumatic stress symptoms
    - Gastrointestinal pain
    - Unexplainable neurologic changes
    - Depression
    - Multiple or erratic visits with a series of vague complaints

    (Annotation #6)

4. Domestic violence can be seen in all age groups, adolescents through seniors. (Annotation #7)
5. When patients confirm that they are or have been in a domestic violent situation, current needs should be assessed as well as a follow-up plan requested with them. (Annotations #10, 11, 12, 13)

6. Interventions in the primary care setting can improve outcomes in identified individuals. (Annotation #11)
7. Regular follow-up can help patients identify the potential impact of domestic violence on their other health conditions. (Annotation #7)

Domestic Violence Algorithm Annotations

1. Implement Education Program on Domestic Violence

Staff Training

Staff, both clinical and office, must receive adequate training in order to effectively identify and respond to domestic violence. Adequate training includes an opportunity to address barriers to identification and intervention as well as to learn the necessary clinical skills. Early in the effort it is essential that training occur within the clinic that ties in with established local community-based advocate programs. Follow-up training over time is also helpful to health care staff in this new and often challenging clinical area. Refer to the original guideline document for available items to assist with staff training (i.e., staff training outline, safety plans for patients, documentation protocols, protocols for dealing with threatening or abusive persons in the clinic setting).

It is not unusual for the same clinic and/or provider to see multiple members of the same family. When domestic violence is involved, this can present with special challenges for safety and confidentiality considerations. Consider having members see different providers.

Patient

Materials should be available in all exam rooms and staff and patient bathrooms. In addition, posters could be displayed in waiting areas with culturally diverse messages indicating that the health care setting is a safe place in which to talk about domestic violence.

Clinical Setting

The goals of domestic violence education in the clinical setting are to increase awareness about this problem as well as to provide information about the internal and external resources available for support. Possible educational strategies include:

- Displaying posters regarding domestic/family violence prevention, including resource contact information, cycle of abuse, cultural influences, etc
- Publishing articles regarding domestic violence and available internal and external resources in employee publications
- Posting violence prevention information in restrooms that would indicate that health care staff members are a safe resource
- Staff training should include use of community-based domestic violence programs as a resource

- Establish strong ties and assure ongoing collaboration with local community- based women's shelters and advocacy programs

Evidence supporting this recommendation is of classes: C, D, R

5. Patient Presenting with Risk Factors/Warning Signs of Domestic Violence?

   Both genders are screened if risk factors or warning signs of domestic violence are present. Either male or female may be a victim, perpetrator or both of domestic violence in either a heterosexual or same-sex relationship. (Refer to Annotation Appendix A entitled "Myths About Domestic Violence" in the original guideline document.) Therefore, providers should not assume that the perpetrator is of the opposite sex.

   The following is a list of common presenting symptoms that may represent the effects of domestic violence:

   Any Injury. Particularly suspicious injuries include:

   - Burns or bruises in unusual locations
   - Central injuries (e.g., chest, breasts, abdomen, pelvis, perineum)
   - Delay in seeking treatment
   - Facial injuries (e.g., teeth, jaw, ruptured eardrum)
   - Human bites
   - Injuries at various stages of healing
   - Injuries from weapons (old scars or new signs)
   - Pattern of injury not consistent with history
   - Previous assault
   - Repeated visits for minor trauma

   Somatic Complaints Without Diagnosis, including:

   - Chronic pain (e.g., abdominal, pelvic, back or neck pain)
   - Fatigue
   - Insomnia/nightmares
   - Unexplainable neurologic changes
   - Vague complaints
   - Headaches

   Sexual Problems/Gynecologic/Gastrointestinal Conditions, including:

   - Coercion in sexual relationships
   - Irritable bowel syndrome
   - Pelvic inflammatory disease (PID)
   - Sexual dysfunction
   - Sexually transmitted diseases (STDs)
   - Unexplained chronic gynecologic problems (e.g., vaginitis, pelvic pain, etc.)

   Psychological Problems, including:

- Alcohol/drug use
- Anxiety/panic attacks
- Post-traumatic stress symptoms (e.g., hyperanxiety, flashbacks)
- Depression
- "Difficult" patient
- Eating disorders
- Excessive requests for tranquilizers, sedatives, or narcotics
- Low self-esteem
- Suicidal ideation or attempt

Pregnancy/Pregnancy Related Problems, including:

- Abnormal bleeding
- Alcohol/drug use, cigarette smoking
- Extreme worry about health of unborn child
- Inadequate maternal nutrition
- Late or inadequate prenatal care
- Past pregnancy complications (e.g., spontaneous abortion, first or second trimester bleeding, poor weight gain, preterm labor, preterm birth, low birth weight infant, abruptio placentae)
- Preterm labor
- Teen pregnancy

Behavioral Presentation, including:

- Angry or anxious body language
- Comments about emotional abuse or a friend who is abused
- Crying or sighing
- Defensiveness
- Minimizing statements
- Searching/engaging (fearful or poor) eye contact
- Very flat affect--little or no emotional expression

Change in Office Visit Patterns, including:

- Appointments canceled by partner
- Change to use of emergency room or urgent/after hours care rather than office visits
- Frequent changes of health care provider
- Frequent late arrival
- Missed or late appointments
- Sudden increase or decrease in frequency of visits

Controlling/Coercive Behavior of Partner/Companion

- Fear of partner, defers to partner to answer questions
- Partner attempts to minimize time patient is alone with provider
- Partner does not allow patient to obtain or take medication
- Partner hovers, appears overly concerned, won't leave patient unattended
- Reluctance to speak in front of or to disagree with partner

Evidence supporting this recommendation is of classes: A, B, C, D, R

6. Provider Offers Education and Resources

Resource materials should not be mailed to the patient's home. Such a mailing might result in greater danger to the patient.

When the patient denies the presence of domestic violence and there is no reason to suspect domestic violence, the health care provider only needs to have resource information available and to convey the message that the health care setting is a safe place to ask for help if violence ever becomes a problem.

At this point the patient may not be ready to openly discuss domestic violence, but may be willing to take written material if that material is available and if it is safe to have in his or her possession. This material might be used by the patient months after the medical encounter.

The patient should also be tactfully reassessed at the next follow-up encounter if domestic violence is suspected. A safety assessment and follow-up discussions can increase the adoption of safety behaviors, possibly preventing future abuse, and reducing danger for both victims and children.

In domestic violence, both or either the male or female may be a victim, perpetrator, or both. In addition to providing education and resources to the victim, providers may want to have resource materials available for the abuser and children who may witness domestic violence.

Evidence supporting this recommendation is of class: B, D

7. Screening for Domestic Violence/Standard Care of Injuries or Symptoms

Screening for Domestic Violence

The screening and assessment interview should be conducted in private, with only the provider and the patient present including screening teens about their dating relationships. It can occur during the initial screen while asking about smoking and taking vital signs. Or it may be done during the social history portion of the encounter. If evaluating the patient for an injury, either the triage nurse or the examining provider could ask the listed questions. The goal for providers is to become comfortable with asking about domestic violence and make it part of the clinical routine, much like gathering information on smoking and alcohol consumption. When screening patients, the cultural, ethnic and religious background of the patient needs to be acknowledged, including ensuring the confidentiality of the interpreters. Patient behaviors such as smiling, minimizing danger, stoicism, and lack of trust in health care staff can easily be misinterpreted.

Introduction or Framing Question

Introducing a domestic violence screening question seems to make both the physician and patient more comfortable. It also helps patients understand that the physician does routine screening and that they are not being singled out for any reason. Here are some examples:

> Unfortunately, violence often plays a role in our families and our communities, so I am asking all of my patients the following question:
>
> At _____ (fill in name of hospital/clinic), we recognize that violence and abuse is common in our patients' lives, so I've begun asking about this routinely.

Screening Questions

The following is a list of questions to be used in screening for domestic violence. Depending upon the clinician's professional style and the nature of the patient's situation, some questions may be more appropriate than others.

During a clinic visit for suspicious symptoms or for any reason, the clinician may want to use a variety of questions, either indirect or direct:

Indirect

- In general, how would you describe your relationship?
- How do you and your partner settle arguments?
- Do you feel safe in your current relationship?

Direct

- Have you been hit, kicked, punched, or otherwise hurt in the past year? If so, by whom?
- Have you or your partner ever used physical force during arguments?
- Do you feel frightened by what your partner says or does?

Refer to Appendix B, "Screening Instruments" in the original guideline document for specific screening tools.

When seeing a patient again who has given an equivocal or affirmative response to previous questions about abuse:

- "We spoke about the anger and abuse at home last time. How are you doing?"

Standard Care of Injuries or Symptoms

- Treat medical injuries as indicated
- Use caution in administering or prescribing sedatives, tranquilizers, or antidepressants
- If the patient shows symptoms of underlying psychological conditions:

- If the patient is acutely suicidal or homicidal, take the appropriate protective action.
- Evaluate symptoms further. Consider a consultation with or referral to mental health/chemical health. Inform the patient that depression, anxiety and chemical abuse are common responses to long-term stress. If assessment of psychiatric symptoms is not appropriate at this visit, evaluate further at return visit.
    - Some patients may be unwilling to consider domestic violence resources or think a domestic violence shelter is for low-income victims. Consider a referral to a mental health professional who has an interest in domestic violence even if the patient doesn't have underlying psychological conditions if the provider thinks the patient might be more receptive.
- Assess for domestic violence before prescribing anxiolytics for patients who suffer from symptoms like recurring headaches, chest pain, pelvic pain, numbness and tingling, or panic attacks.
    - Patients may be unwilling to follow-up on referrals and need further education regarding the link between domestic violence and their health issues (e.g., high blood pressure, other chronic illnesses). Arrange for follow-up visits.

Evidence supporting this recommendation is of classes: B, C, D, M, R

8. Domestic Violence Suspected?

   If there is something about the patient's injuries, behaviors or reactions that leads you to believe there is or has been abuse, recognize this as a sensitive part of the encounter. Most victims will find it difficult to discuss an abusive situation. The following are some ways to proceed in a nonthreatening, respectful manner:

   - Remain nonjudgmental and supportive
   - Be alert to any cultural influences which may be present
   - Be clear with the patient about what characteristics of the injury lead you to believe that he or she may have been assaulted. For example: "The shape of the bruise on your face fits the shape of a fist and makes me wonder if you have been hit." If the patient denies abuse, do not insist that you are right. Accept the response
   - Patient education materials and posters should be pointed out
   - Inform the patient that domestic violence isn't necessarily only physical, but may also be emotional or sexual in nature
   - Sometimes patients are reluctant to accept literature. You may want to offer information indirectly (e.g., "Perhaps someone you know can use this.").
   - Be certain to inform patients that this information is confidential, and that the clinic setting is a safe place to discuss such problems
   - Mention that under state law, no one has the right to abuse anyone, and no one ever deserves to be abused--physical abuse is illegal

- It takes time and trust for patients to disclose abuse. Continue to ask and be supportive

9. Patient Confirms Domestic Violence?

   At this point, the patient will either confirm or deny that domestic violence is an issue in the lives of abused men and women. A patient may confirm domestic violence as part of a previous experience (e.g., a former relationship, parents, etc.) If this situation no longer exists, or if the relationship has ended, the provider should evaluate the patient's assessment of his or her current needs. The following should be done immediately when domestic violence is confirmed by the patient:

   - Validate the patient's feelings (e.g., fear, shame, etc.)
   - Support the patient's right not to be hurt
   - Acknowledge the potential for further harm

   The healing process is assisted by education about domestic abuse.

   Educational materials should be shared with the patient regarding the cycle of violence and the dynamics of power and control (refer to Appendix D, "Review of Violence Cycle Models" and Appendix E, "Safety Planning" in the original guideline document for further details).

   Evidence supporting this recommendation is of class: R

10. Discuss Immediate Safety Status

    Discussing the patient's immediate safety will enable an abused individual to decide how best to proceed. Consider asking the following questions:

    - Is the patient in immediate danger? (What does the patient anticipate will happen when/if he/she returns home?)
    - Does the abuser have or use a weapon? Has the abuser threatened to kill the patient?
    - Is the abuser violent toward other family members, or pets?
    - Does the abuser use drugs or alcohol?
    - Does the patient use drugs or alcohol to cope?
    - Has the patient ever attempted or thought of attempting suicide?

    Evidence supporting this recommendation is of classes: A, D, R

11. Review Resources/Offer Support/Offer Advocate

    Interventions in the primary care settings can improve outcomes in identified individuals.

    The Danger Assessment is a tool to help assess safety status. See Appendix C, "Danger Assessment" and Appendix E, "Safety Planning" in the original guideline document for a copy of a safety planning form.

If the patient appears to be in IMMINENT DANGER of being harmed, consider the following:

- Provide imminent safety from the abuser while the patient is in the medical setting and during any transfers to other settings
- Encourage abused women and men to consider finding a safe place to stay--with family, friends, a battered women's shelter
- If the patient chooses not to return home, a health care staff person or advocate needs to offer assistance in obtaining safe lodging
- Review resources and offer written materials
    - Provide the patient with a copy of a safety plan and an opportunity to discuss the plan if appropriate
    - Offer the patient resource material on domestic violence. If the patient feels it is unsafe to take the material, at least make sure he or she has the phone number of a local shelter or hotline, and that he or she keeps the number in a safe place
    - Do NOT suggest couples counseling, as clinical evidence suggests the perpetrator may retaliate when the couple is alone
- Offer a domestic violence advocate:
    - Offer to help put the patient in touch with a domestic violence advocate. Advocates are trained to help the patient plan for safety and can provide for immediate shelter, transitional services, and legal advocacy.
    - Provide the patient with a private and safe place (away from abuser) from which to talk with an advocate by phone or in person. Offer to assist the patient with this call if appropriate.
    - Site-based advocacy services can provide face-to-face support on a 24-hour basis. Settings without on-site services can rely on local shelters or hot lines for immediate telephone contact with the patient.
- Refer to the original guideline document for information about available crisis lines.
- At this point the patient may not be ready to openly discuss domestic violence, but may be willing to take resource materials. Discuss safe places to keep this information; it may be used months after the health care encounter. The patient should also be tactfully reassessed at the next encounter.

Evidence supporting this recommendation is of classes: A, B, R

12. Plan For Future Follow-Up/Documentation

Plan for Future Follow-Up

- Ask the patient to schedule a return visit for follow-up in order to provide ongoing treatment of injuries, further assessment, and/or to allow the patient to get support.
- During future visits, continued assessment and support are extremely important and should be provided in a way which is driven by the patient's readiness, not the provider's timetable for change. Simple questions like "How are things going at home?"

convey that the health care setting continues to be a safe place in which to discuss domestic violence.

Documentation

The primary responsibility for health care providers dealing with domestic violence includes identifying and acknowledging the abuse, providing sensitive support, clearly documenting the abuse, and providing referral and resource information.

Proper documentation is critical in the event that the victim chooses to take legal action at the time of the visit or sometime in the future.

Use the subjective-objective-assessment-plan (SOAP) format to provide the standard information, as you would for any other patient encounter. Refer to the original guideline document for examples of suggested documentation using the SOAP format.

Coding

Refer to the original guideline document for information on coding.

Confidentiality

Confidentiality is a critical issue in all work with patients. The area of domestic violence poses an additional challenge in regards to patient safety. Domestic violence screening should be done with only the patient and health care provider present. If an interpreter is necessary, do not use friends or family but use a professional interpreter service or language line services.

Evidence supporting this recommendation is of classes: D, R

Definitions:

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study

- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for Domestic Violence.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Guideline recommendations may improve the care of domestic violence victims by providing clinicians with a "road map" for identifying and effectively intervening in domestic violence-related heath care problems.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Guideline recommendations may improve the care of domestic violence victims by providing clinicians with a "road map" for identifying and effectively intervening in domestic violence-related heath care problems.
- Safety assessment and discussion of the cycle of violence and safety behaviors can make a positive difference. In a study of 132 abused pregnant mothers, including white, Hispanic, and black women, a safety intervention protocol significantly increased the safety behaviors adopted by the women.

POTENTIAL HARMS

Sedatives, tranquilizers, anxiolytics, and antidepressants can undermine the patient's ability to deal with abusive situations; therefore, caution should be exercised in prescribing to victims of domestic violence. The domestic violence victim whose symptoms are treated without the underlying cause being diagnosed enters a cycle of contacts with medical and mental health providers in which he/she can become increasingly debilitated while at the same time exhausting resources available to the patient.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.
- This clinical guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions they may have.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for release, a member group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

Key Implementation Recommendations

The following system changes were identified by the guideline work group as key strategies for health care systems to incorporate in support of the implementation of this guideline.

1. Establish the health care setting as a safe, comfortable appropriate place in which to discuss domestic violence issues. Opportunities exist in the form of patient education, informational displays, etc.
2. Train staff to recognize and screen patients for abuse, including:
    - Recognition that domestic violence may be in the form of physical, emotional/psychological, social and sexual abuse, and may exist in both heterosexual and same-sex relationships.
    - Patients, whether not experiencing abuse or denying abuse, are routinely offered information regarding domestic violence resources and support in a non-threatening manner.
    - Patients confirming abuse are assessed for their immediate safety status, have available options and written resource materials offered, and are offered contact with a domestic violence advocate.
    - Documentation is thorough and complete, supported by subjective and objective data, and maintained in a highly confidential manner.
3. Develop a step-by-step safety plan to guide the patient should he/she choose to seek additional assistance.
4. Establish relationships with community resources to expand resources available to victims of domestic violence.

IMPLEMENTATION TOOLS

Clinical Algorithm
Pocket Guide/Reference Cards
Quality Measures

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED NQMC MEASURES

- Domestic violence: percentage of health care staff trained in initial assessment of problems of domestic violence every twelve months.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Nov. 51 p. [111 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 Jun (revised 2004 Nov)

GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical Group, Community-University Health Care Center, Dakota Clinic, ENT Specialty Care, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Mille Lacs Health System, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Care System, North Suburban Family Physicians, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Pilot City Health Center, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, Saint Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals and Health System, Southside Community Health Services, Stillwater Medical Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Ltd., Winona Health

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PreferredOne, and UCare Minnesota. In-kind support is provided by the Institute for Clinical Systems Improvement's (ICSI) members.

GUIDELINE COMMITTEE

Committee on Evidence-Based Practice

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In the interest of full disclosure, ICSI has adopted a policy of revealing relationships work group members have with companies that sell products or services that are relevant to this guideline topic. The reader should not assume that these financial interests will have an adverse impact on the content of the guideline. Readers of the guideline may assume that only work group members listed below have potential conflict of interest to disclose.

No work group members have potential conflicts of interest to disclose.

ICSI's conflict of interest policy and procedures are available for review on ICSI's website at www.icsi.org.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Nov. 40 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Institute for Clinical Systems Improvement (ICSI) Web site.

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AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- ICSI pocket guidelines. April 2004 edition. Bloomington (MN): Institute for Clinical Systems Improvement, 2004. 404 p.

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PATIENT RESOURCES

None available

NGC STATUS

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